IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

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BUREAU OF FACILITY STANDARDS
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Boise, Idaho 83720-0036
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November 12, 2009

Rex Redden
Idaho Falls Group Home #2 Wanda
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #2 Wanda, provider #13G029

Dear Mr. Redden:

This is to advise you of the findings of the complaint survey of Idaho Falls Group Home #2 Wanda, which was conducted on October 28, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **November 25, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by November 25, 2009. If a request for informal dispute resolution is received after November 25, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

M. Williams

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/10/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G029	A. BUILDING _____ B. WING _____	C 10/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #2 WANDA	4360 WANDA STREET AMMON, ID 83406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiency was cited during the complaint survey. The survey was conducted by: Monica Williams, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations/symbols used in this report are: QMRP - Qualified Mental Retardation Professional	W 000		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to provide sufficient direct care staff on graveyard shift to manage and supervise individuals in accordance with their IPPs for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This had the potential to impede staffs' ability to consistently meet individuals' identified night time needs. The findings include: 1. Observations were conducted in the facility on 10/27/09 from 4:00 - 4:40 p.m. and on 10/28/09 from 6:45 - 7:10 a.m. During that time, Individuals #1, #5, and #6 were noted to be	W 186	W-186 1. All individuals have the potential to be affected by this practice. Additional staff have been hired so that two staff will always be on the night shift to care for all clients. 2. Supervisor will spend at least one day per week on the graveyard shift providing on going training and support for the staff. The QMRP will do follow up and on going training with the supervisor on a weekly bais during weekly meetings. 3. Correction was made on 10-29-09	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 186	Continued From page 1 physically assisted to the bathroom and staff were noted to accompany them in to the bathroom, with the door closed. Further, staff were noted to assist Individuals #1, #4, #5, #6, and #7 to ambulate throughout the facility. Direct care staff, the Lead Worker, the Home Supervisor, the QMRP, and the Administrator were interviewed during the course of the survey. When asked about staffing, the QMRP stated on 10/27/09 during the entrance conference, there was one staff on duty during the graveyard shift (10:00 p.m. - 6:00 a.m.). When asked, the Lead Worker and the Home Supervisor both stated during an interview on 10/27/09 at 12:50 p.m., Individuals #2, #5, and #6 had formal toileting programs that were implemented every two hours throughout the night. The toileting schedules were staggered such that programs were implemented every hour. Individuals #5 and #6 required physical assistance to ambulate to the bathroom. Individual #6's toileting plan, dated 11/07, stated she was not to be left unattended in the bathroom. The Lead Worker and the Home Supervisor both stated during the above noted interview that Individuals #1, #3, #4, #7, and #8 had informal (as needed) toileting plans throughout the night. Individual #1 had an unsteady gait and required stand-by assistance from staff while ambulating and he was not to be left unattended in the bathroom. Additionally, Individual #1 had sleep apnea who, on average, slept 5 of 7 nights. Further, Individual #2 was placed on one-to-one supervision if he engaged in aggression or biting behavior. The Lead Worker and the Home	W 186		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #2 WANDA	4360 WANDA STREET AMMON, ID 83406

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W 186	Continued From page 2 Supervisor both stated that based on individuals' needs, a second staff was needed on graveyard shift. A graveyard shift staff was interviewed on 10/29/09 at 6:50 a.m. When asked, staff stated it was very difficult to meet the needs of Individuals #1 - #8 and complete the required graveyard deep cleaning duties. When asked, the QMRP and the Administrator both stated on 10/28/09 at 9:15 a.m., the need for a second staff on graveyard shift was identified in April 2009. The facility failed to ensure there were sufficient direct care staff on graveyard shift to meet the needs of Individuals #1 - #8.	W 186		

PRINTED: 11/10/2009
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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IDAHO FALLS GROUP HOME #2 WANDA	4360 WANDA STREET AMMON, ID 83406

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MM857	16.03.11.270.08(e) Qualified Training There must be sufficient appropriately qualified training and habilitation personnel and necessary supporting staff available to carry out the residents' training and habilitation program. This Rule is not met as evidenced by: Refer to W186.	MM857	Refer to W186	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin Assistant — (X6) DATE: 12/10/09

STATE FORM 6899 EMEP11 If continuation sheet 1 of 1

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 12, 2009

Rex Redden
Idaho Falls Group Home #2 Wanda
P.O. Box 50457
Idaho Falls, ID 83405-0457

Provider #13G029

Dear Mr. Redden:

On **October 28, 2009**, a complaint survey was conducted at Idaho Falls Group Home #2 Wanda. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004357

Allegation: Individuals physically assault each other and the facility is not doing enough to keep individuals safe.

Findings: An unannounced on site complaint survey was conducted on 10/27/09 and 10/28/09. During that time, observations, incident reports, client to client aggression reports and investigations were reviewed, record review, and staff interviews were conducted with the following results:

Observations were conducted on 10/27/09 and 10/28/09 for a cumulative one hour 45 minutes. During that time, individuals were noted to engage in appropriate behavior and no physical assaults were noted.

Incident reports, dated 6/1/09 to 10/26/09, were reviewed and did not contain information related to individuals physically assaulting each other. Client to Client Aggression reports, dated 6/1/09 - 10/26/09, were reviewed. There was one report, dated 8/25/09, which showed one individual pushed another individual. The report showed staff immediately intervened and there were no injuries.

Two investigations were reviewed for the same time frame noted above. One investigation, dated 10/21/09, showed that two individuals were in the living room playing with toy cars at 11:30 p.m. The staff person was in the kitchen preparing food items. According to the investigation, when staff looked up, one individual (who was a minor) was on top of the second individual (who was an adult). At that point, the staff immediately intervened and redirected the first individual back to bed. The investigation showed the second individual was assessed for injuries which included bite marks and slight bruising; there was no broken skin or bleeding. The investigation showed all appropriate parties were notified of the incident. The investigation showed staff had not followed standard protocol that when an individual got out of bed, they were to be redirected back to bed. The investigation showed the staff person was re-trained on the protocol and a monitoring system was implemented to ensure it was being followed.

Four individuals' record were selected for review. Of those four, one individual had two behavior plans related to aggression and biting behavior. That individual's record also contained a protocol, dated 4/09, which stated if the individual engaged in aggression or biting behavior, the individual was immediately placed on one to one staffing.

Direct care staff, the Lead Worker, the Home Supervisor, the Qualified Mental Retardation Professional (QMRP) and the Administrator were interviewed during the course of the survey. When asked, the QMRP stated on 10/27/09 during the entrance conference, there were four staff on the day shift (6:00 a.m. - 2:00 p.m.), four staff on the evening shift (2:00 - 10:00 p.m.), and one staff on the graveyard shift (10:00 p.m. - 6:00 a.m.).

When asked, the Lead Worker and the Home Supervisor both stated during an interview on 10/27/09 at 12:50 p.m., that of the eight individuals residing in the facility, three individuals had formal toileting programs that were implemented every two hours throughout the night. The toileting schedules were staggered such that programs were implemented every hour. Two of the three individuals required physical assistance to ambulate to the bathroom. One individual was not to be left unattended in the bathroom. Five individuals had informal (as needed) toileting plans throughout the night. One of the five individuals had an unsteady gait and required stand-by assistance from staff while ambulating and was not to be left unattended in the bathroom. Additionally, that individual had sleep apnea who, on average, slept 5 of 7 nights. Further, one individual was one-to-one if the individual engaged in aggression or biting behavior. The Lead Worker and the Home Supervisor both stated that based on individuals' needs, a second staff was needed on graveyard shift.

When asked, the QMRP and the Administrator both stated on 10/28/09 at 9:15 a.m., the need for a second staff on graveyard shift was identified in April 2009.

Therefore, the allegation was unsubstantiated as the facility had behavior plans and protocols in place to ensure individuals' safety. However, deficient practice was identified related to staffing on the graveyard shift and the facility was cited at W186.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw